STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555486	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Healthcare & Wellness Center	430 Willow Street Alameda, CA 94501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, interviews, record review, and policy review, the facility failed to ensure that three of three residents (Resident (R) 21, 77, and 89) reviewed for dignity out of a sample of 47 residents, did not have signs hanging above bed with medical information on them. Findings include: Review of facility policy titled, "Resident Rights-Quality of Life," revised 03/2017, revealed "To ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, consistent with the resident's comprehensive assessment and plan of care. Procedure: .Facility staff treats cognitively impaired residents with dignity and sensitivity." 1. Review of R21's "Admission Record," located under tab "Profile" in the electronic medical record (EMR) indicated that R21 was readmitted to the facility with a diagnosis of cerebral palsy (CP), and malignant neoplasm of prostate. During observation on 08/05/24 at 12:35 PM, there was a sign on R21's overbed light that read " [R21 Room number] A is a FEEDER!! Diet: pureed, nectar thick liquid. R21 eats cheerios cereal each meal-pour milk in bowl. He can tolerate unsure? Ask charge nurse!" Review of quarterly "Minimum Data Set (MDS)" assessment, located under the tab "MDS" with "Assessment Reference Date (ARD)" of 06/14/24 indicated that R21's upper and lower extremities had impairment on both sides, and R21 was dependent on staff for eating. The "Brief Interview of Mental Status (BIMS)" was 15 out of 15 making R21 cognitively intact; however, during tour of the facility, R21 was alert yet disorganized. During further observations on 08/06/24 at 9:30 a.m., and 3:00 p.m., revealed that the sign was hanging above R21's bed. In addition, on 08/07/24 at 10:29 a.m., the sign was there. At 10:29 a.m., on 08/08/24, the sign was hanging above R21's bed. 2. Review of R77's "Admission Record," located under tab "Profile" indicated that R77 was readmitted to the facility on [DATE] with a diagnosis of nontraumatic intracranial hemorrhage and cognitive communication deficit. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Healthcare & Wellness Center	430 Willow Street Alameda, CA 94501

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 08/05/24 at 12:35 p.m., observed a sign on the overbed light that indicated "[R77 Room Number] B -Is a FEEDER!! He takes his time chewing!! Diet: mechanical soft, thin liquid. Aspiration precautions. He has supplement shakes in cabinet if he does not eat at least 50%. Ask charge nurse if you need more information!" Further observation, on R77's corkboard over nightstand had a sign that indicated "*[Resident Room Number] B*Alert* Seizure Precautions." In addition, observed signs on 08/06/24 at 10:41 a. m., 08/07/24 at 9:30 a.m., and 3:00 p.m. At 08/08/24 at 10:29 a.m., observed signs above R771's nightstand and bed. Review of quarterly "MDS" assessment with "ARD" of 06/21/24, located under the EMR's tab "MDS" indicated R77 was dependent on staff for eating and had upper extremity impairment on both sides. The BIMS was zero out of 15, making R77 severely impaired. 3. Review of R89's "Admission Record," located under the "Profile" tab in the EMR indicated that he was readmitted to the facility on [DATE] with a traumatic brain injury (TBI), and schizophrenia. During observation on 08/05/24 at 11:58 a.m., observed three signs hanging on the wall above R89's bed. The first sign which was observed on the left side indicated "Resident is a Feeder!! *Fall risk* Bed at lowest setting. See nurse for information." The second sign was observed in the center indicated "Seizure Precautions. *Alert. *" The third sign on the right side indicated "R89 is Aspiration Precautions!! Diet: Pureed, thicken liquids. Keep resident not less than 30 degrees." In addition, the three signs were observed on 08/06/24 at 10:43 a.m., 08/07/24 at 9:40 a.m., and 3:10 p.m. Review of R89's quarterly "MDS" assessment with "ARD" of 05/07/24, located under tab "MDS" in the EMR indicated that R89 was dependent on staff for eating. The BIMS was 13 out of 15 making R89 cognitively intact, and interviewable. Interview with the Director of Nursing (DON) on 08/08/24 at 12:25 p.m., confirmed that these signs should not be up. DON Stated that this information should be covered and/or applied to the Kardex.

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F 0554

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Allow residents to self-administer drugs if determined clinically appropriate.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 25232

40824

Based on observations, interviews, record review, and policy review, the facility failed to ensure residents who self-administered medications had a self-administration of medication assessment, a physician's order, and a care plan completed for two of two residents (Resident (R) 44 and R73) reviewed for self-administration of medications. This failure to assess and care plan residents for self-administration of medications increases the potential risk of medication errors for residents.

Findings include:

Review of facility's policy titled, "Medication-Self Administration," revised 01/01/12, revealed, "To provide residents with the opportunity to self-administer medications when determined they are capable to do so by the attending physician and the Interdisciplinary team (IDT).

Procedure: .

3. For a final determination of the resident's ability to self-administer medications, the Assessment for Self-Administration of Medications will be presented to the resident's attending physician.

A. The resident may not begin self-administration of medications prior to the approval of the IDT and attending physician.

i. The attending physician must provide a written order permitting the residents to self-administer medication.

B. If the IDT and attending physician do not approve self-administration of medications, the resident or their representative will be informed, and the reason will be documented in the medical record.

C. If the IDT team and attending physician approve self-administration of medications, the medications will be placed in a secured drawer or cabinet that is easily accessible to the resident.

i. Controlled drugs (i.e. narcotics, hypnotics, etc.) are not to be left for open access to the resident .

7. Documentation

A. The physician's order approving the self-administration of medication will be maintained in the resident's medical record.

B. The assessment for self-administration of medications will be maintained in the resident's chart.

(continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Self-administration of medications will be documented in the resident's care plan and the medication administration record." 1. Review of R73's "Admission Record," located under the tab "Profile" in the electronic medical record (EMR) indicated that R73 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). Review of the R73's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/24, located under the MDS tab of the EMR revealed the resident had a Brief Interview for Mental Status score of 15 out of 15 meaning the resident is cognitively intact. During a concurrent observation and interview on 08/05/24 at 10:00 a.m., with R73, a red albuterol sulfate hydrofluoroalkane (HFA) inhaler was observed upside down in a clear cup on her overbed table. R73 stated that this inhaler was the one she used at home as needed (PRN). During a concurrent observation and interview on 08/06/24 at 10:35 a.m. with R73, R73's albuterol sulfate HFA inhaler lying on her overbed table. Interview with Registered Nurse (RN)1 at 10:36 a.m., confirmed that R73 had inhaler in her room and that R73 does not have a physician's order to keep the inhaler. During an observation on 08/06/24 at 10:35 AM, R73's inhaler from home was laying on the overbed table. Review of R73's "Physician's Orders," dated August 2024, located under the tab "Orders" in the EMR indicated no evidence to self-administer medication and/or an order for the inhaler. Review of the "Assessment" tab in the EMR indicated no evidence of a self-administration of medication assessment. Review of the "Care Plan" tab in the EMR indicated no evidence of a care plan developed for self-administration of medication. During an interview on 08/07/24 at 2:25 p.m., with the Director of Nursing (DON), DON confirmed that residents should not have medications at bedside unless the resident has been assessed, has a physician order, care plan developed for self-administration of medication and a way to lock up the medication. Confirmed that R73 does not have any of these. 2. Review of R44's Admission Record located in the electronic medical record (EMR) under the Resident tab revealed an original admitted [DATE] and readmission on 07/06/21. R44's primary diagnosis was end stage renal disease. Review of R44's Care Plan revised 07/26/24 and located in the EMR under the Care Plan tab did not include self-administration of medications. Review of R44's annual MDS) with an ARD of 05/29/24 located in the EMR under the MDS tab included a BIMS score of 15 out of 15, indicated she was cognitively intact. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R44's Physician Orders, located in the EMR under the Orders tab included an order. dated 07/02/24, for sevelamer carbonate oral tablet 800 mg (milligrams), give two tablets by mouth with meals. Review of R44's Assessment tab in the EMR, did not include a Self-Administration of Medication assessment. During an observation and interview on 08/05/24 at 11:23 a.m., with R44, R44 had a medication cup on her over the bed table with two white tablets in it. R44 stated the agency nurses don't trust her, but the nurses that had been there a while and knew her are okay leaving medications at the bed side. R44 was unable to state whether she had a Self-Administration of Medication assessment. During an interview on 08/05/24 at 11:39 a.m., with Licensed Vocational Nurse (LVN) 7, LVN7 confirmed that she had administered R44's sevelamer carbonate oral tablet 800 mg tablets and left them on R44's bedside table. LVN7 stated that R44 was very particular and preferred to take her pills with her meals, so she leaves them there for her and goes back after lunch to make sure she had taken them. LVN7 confirmed that R44 had not had a Self-Administration of Medication assessment. During an interview on 08/05/24 at 12:17 p.m., with DON, DON confirmed that R44 did not have a Self-Administration of Medication assessment but should have if medications were going to be left at the bedside.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27375 Based on observation, interview, record review, and policy review, the facility failed to provide privacy during care in the resident's room for one of 45 sampled residents (Residents (R) 108). This failure could potentially have a negative impact on the quality of life for the affected resident. Findings include: Review of R108's Face Sheet located in the Profile tab of the electronic medical record (EMR), revealed R30 was admitted to the facility on [DATE] with the following diagnoses: unspecified dementia, unspecified severity, without behavioral, disturbance, psychotic disturbance, mood disturbance, and anxiety, moderate protein-calorie malnutrition, Alzheimer's disease, unspecified disorder involving the immune mechanism, unspecified, essential (primary) hypertension difficulty in walking, Review of R108's Quarterly, MDS with an ARD of 6/17/24 located in the resident's EMR under the MDS tab revealed a BIMS score of eight out of 15 which indicated R108 was moderately impaired for decision-making. During an observation on 08/05/24 at 11:39 a.m., with Certified Nurse Aide (CNA) 5, CNA 5 was providing care to R108 with the door open. R108 was in a three-person room with R108 in the middle bed. The privacy curtain was drawn on each side of R108's bed. While this surveyor was standing outside of R108's room, R108's legs were visible while CNA5 performed peri care (washing the genitals and anal area) on R108. In an interview on 08/05/24 11:45 a.m., with CNA5, CNA 5 stated a resident's room does not have to be closed while doing care with a resident if the curtains are drawn. In an interview on 08/05/24 at 11:52 a.m., the Regional Quality Management Consultant (RQMC) stated best practice is to close a resident's door while providing resident care and ask other residents in the room if it is okay to close the door. In an interview on 08/05/24 at 12:11 p.m., CNA6 stated resident doors should be closed and curtains drawn when doing peri care, not unless resident or residents state keep the door open. In an interview on 08/09/24 at 4:06 p.m., the Director of Nurses stated her expectation while staff are providing peri care is to have the curtains drawn all the way around the bed or close the door. Record review of the facility's policy and procedure titled, Resident's Rights with a revised date of 01/01/12, indicated, I. State and federal laws guarantee certain basic rights to all residents of the Facility. These rights include, but are not limited to, a resident's right to: D. Privacy and confidentiality.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 40824 Based on observations and interviews, the facility failed to maintain air conditioning filters for one of four residential units. This failure had the potential to negatively affect the respiratory system of 21 residents residing on the subacute unit, 11 of 21 residents were on ventilators. Findings include: Review of the facility's policy titled, Heating and Air Conditioning System Inspection revised on 01/01/12 indicated the purpose of the policy was To protect the health and safety of residents, visitors, and Facility Staff .Inspections are the responsibility of the Maintenance Department . During an observation on 08/07/24 at 1:00 p.m., the portable air conditioner at the end of the subacute resident hall had three filters with a thick, gray film caked on all three filters. During an interview on 08/07/24 at 1:48 p.m., with the Maintenance Supervisor, Maintenance Supervisor stated maintenance was responsible for maintaining and cleaning the portable air conditioner. He stated they last cleaned the filters in July 2024 and after looking at the filters today they need to be done again. When asked if they kept a log or had a system to assist with tracking items needing regular maintenance, he stated he did not.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on interviews, record review and policy review, the facility failed to ensure that an allegation of physical abuse was reported to the State survey agency (SSA) for one of one resident (Resident (R) 23) reviewed for abuse out of a sample of 47 residents. Findings include: Review of facility's policy titled, "Abuse Prevention and Management," revised on 05/30/24, revealed, "The facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment. The facility develops policies, procedures, training programs, and screening and prevention systems. The facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies .7. Notification of Outside Agencies for All Allegations of Abuse. a. The Administrator or designated representative will notify law enforcement, by telephone immediately, or as soon as practicably possible, but no longer than (2) hours of an initial report and send a written SOC341 report to the Ombudsman, Law Enforcement, and California Department Public Health (CDPH) within (2) hours." Review of "Admission Record," under the tab "Profile" in the electronic medical record (EMR) indicated that R23 was admitted to the facility on [DATE] with a diagnosis of chronic pain, anxiety, and depression. R23's "Brief Interview for Mental Status (BIMS)" revealed that R23 was a 14 out of 15 making R23 cognitively intact. Interview with R23, during the initial tour of the facility, on 08/05/24 at 12:15 PM, R23 said that between 2:00 AM-3:00 AM that the Certified Nursing Assistant (CNA) 3 was rough cleaning her and when asked to be gentler, CNA3 was rougher. R23 stated she did not mention to the staff. The surveyor made the Director of Nursing (DON) aware of this allegation of abuse on 08/05/24 at 12:37 PM. Review of facility provided document titled, "Report of Suspected Dependent Adult/Elder Abuse," dated 08/05/24, revealed, " .R23 reported to [name of surveyor] that CNA3 on night shift last night was rude and rough during care. R23 identified [name of CNA3] as the person that was rude and rough during care. Review of facility provided Fax, dated 08/05/24 at 8:06 PM, indicated that six pages including cover was faxed to the SSA and Ombudsman. Interview with the Administrator on 08/06/24 at 10:00 AM, confirmed that the report to the SSA was late.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interviews, record reviews, and policy review, the facility failed to ensure one of three residents (Resident (R) 30) reviewed for hospitalization out of a total sample of 46 were given a written notice prior to or as soon as practical following transfer to the hospital. Additionally, there was no documentation that the Ombudsman was notified of the transfer for R30. This failure created the potential for residents or their responsible party to not have the information needed to understand their transfer to the hospital. Findings include: Review of the facility's policy titled, Discharge and Transfer of Residents revised 02/2018 indicated .Upon transfer to the acute hospital the resident/resident representative will be given an opportunity to execute a Bed Hold .The Facility may transfer or discharge a resident with an order from the resident's physician for . The discharge is necessary for the welfare of the resident, and needs cannot be met in the facility .Prior to discharge, Social Service Staff or Nursing will provide the resident/resident representative with the Notice of Proposed Transfer and Discharge document. Social Services/Designee will keep a copy of the Notice of Proposed Transfer and Discharge that was provided to the resident/ resident representative. This will be placed in the medical record . Review of the undated Admission Record in the electronic medical record (EMR) under the Profile tab revealed R30 was admitted to the facility on [DATE]. Review of R30's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/02/24 located in the EMR under the MDS tab did not include a Brief Interview for Mental Status (BIMS) due to the resident not being able to participate. Review of the Census, located in the EMR under the Census tab, revealed on 02/21/23 R30 was discharged to the hospital and returned to the facility on [DATE]. Review of R30's document titled, SNF/NF to Hospital Transfer Form, dated 02/21/23 indicated the reason for transfer was gastrointestinal bleeding. Review of R30's document titled, Notice of Proposed Transfer and Discharge. dated 02/21/23 provided by Social Services (SS1) indicated the resident/resident representative received a copy of the notification, with no documentation indicating the Ombudsman was notified. During an interview on 08/08/24 at 5:42 PM, SS1 stated that it was her responsibility to send out the transfer and discharge notifications to the resident/ resident representative and the Ombudsman. Upon review of her documents, SS1 stated that she was unable to locate the Ombudsman notification for the transfer and discharge notification for R30's hospitalization on [DATE].

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F 0625

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40824

Based on interview, record review, and policy review, the facility failed to ensure two out of two sampled residents who were reviewed for hospitalization (Residents (R)30 and R100) were provided with a bed hold notice within 24 hours of emergent transfer to the hospital. This failure increased the potential that residents would not know to request a bed hold and may be unable to return to the facility.

Findings include:

Review of the facility's policy titled, Bed Hold, revised 07/2017,indicated , To ensure that the resident and/or his/her representative is aware of the Facility's bed-hold policy, and that such policy complies with state and federal law and regulations .The Facility notifies the resident and/or representative, in writing, of the bed hold, option, any time the resident is transferred to an acute care hospital or requests therapeutic leave.

1. Review of R30's Admission Record, located in the electronic medical record (EMR) under the Resident tab revealed an original admitted [DATE] and readmission on 09/21/22. R30's primary diagnosis was chronic respiratory failure with hypoxia.

Review of R30's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/02/24 located in the EMR under the MDS tab did not include a Brief Interview for Mental Status (BIMS) due to the resident not being able to participate.

Review of the Census, located in the EMR under the Census tab, revealed on 02/21/23 R30 was discharged to the hospital and returned to the facility on [DATE].

Review of R30's document titled, SNF/NF [Skilled Nursing Facility/Nursing Facility] to Hospital Transfer Form dated 02/21/23, indicated the reason for transfer was gastrointestinal bleeding.

Review of R30's EMR did not include a Bed Hold notification.

2. Review of R100's Admission Record, located in the EMR under the Resident tab revealed an original admitted [DATE] and readmission on 06/07/22. R100's primary diagnosis was type two diabetes mellitus with diabetic chronic kidney disease.

Review of R100's quarterly MDS with an ARD of 06/02/24 located in the EMR under the MDS tab included a BIMS score of 11 out of 15 indicating she was moderately cognitively impaired.

Review of the Census, located in the EMR under the Census tab, revealed on 04/09/24 R100 was discharged to the hospital and returned to the facility on [DATE].

Review of R100's document titled, SNF/NF to Hospital Transfer Form, dated 04/09/24 indicated the reason for transfer was fever, coughing, and wheezing.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R100's EMR did not include a Bed Hold notification. During an interview on 08/08/24 at 6:30 PM with Social Services (SS1) stated that she did provide Bed Hold notifications. During an interview on 08/09/24 at 10:30 AM, the Administrator confirmed that the Admissions Coordinator should have provided Bed Hold notifications for R30 and R100 but did not.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 25232 Based on record review, interview, and review of the Resident Assessment Instrument (RAI manual) the facility failed to ensure that one resident (Resident (R) 86) out of 47 sampled residents' Minimum Data Set (MDS) assessments were transmitted in a timely manner. Findings include: Review of Center for Medicare and Medicaid Services (CMS) Long-term Care Facility Assessment Instrument 3.0 User's Manual, version 1.18.11, dated 10/23, revealed, .Chapter 2: Assessments for the Resident Assessment Instrument, 2.6: Required OBRA Assessments for the MDS .RAI OBRA-required assessment summary for discharge assessment .MDS completion date (Z0500B) no later than no later than discharge date + 14 calendar days .Transmission date no later than MDS completion date + 14 calendar days. Review of "Admission Record," located under tab "Profile" in the electronic medical record (EMR) indicated that R86 was admitted to the facility 02/02/24 with a diagnosis including fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, spinal stenosis, and chronic kidney disease. Review of discharge return not anticipated "MDS" assessment, located under tab "MDS" in the EMR with "Assessment Reference Date (ARD)" of 03/01/24 indicated completed on 03/09/24; however, no evidence of being transmitted. Review of "Progress Note," located under tab "Progress Notes" in the EMR dated 03/01/24 indicated "Patient was discharged .medication was sent with patient along with discharge packet." Interview on 08/08/24 at 4:22 PM, with MDS1, MDS 1 confirmed that this assessment was not transmitted after being completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interviews, record reviews, and facility policy review, the facility failed to ensure two of three residents (Resident (R)4 and R99) had accurate care plans which were reviewed and revised on a quarterly basis. Additionally, the facility failed to ensure that one of three residents (R101) was invited to participate in care conferences. This failure increased the risk of the residents' preferences and concerns not being included in the plan of care. Findings include: Review of the facility's policy titled Comprehensive Person-Centered Care Planning revised 08/24/23, indicated, .changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident .The comprehensive care plan will be periodically reviewed and revised by IDT [interdisciplinary team] after each assessment which means after each MDS assessment as required, except discharge assessments .The Facility must provide the resident and representative if applicable, reasonable notice of care planning conferences to enable resident and representative participation . 1. Review of R4's Admission Record, located in the electronic medical record (EMR) under the Resident tab, revealed an original admitted [DATE]. R4's primary diagnosis was acute and chronic respiratory failure. Comorbidities included reduced mobility and muscle weakness. Review of R4's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/01/24 located in the EMR under the MDS' tab included a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicated she was cognitively intact. Additionally, the MDS did not include the use of splints. Review of R4's Care Plan, located in the EMR under the Care Plan tab and revised on 07/01/24 indicated, Maintain muscle strength with active/active assistive/passive ROM [range of motion] and prevent contractures with use of splints . Review of R4's Order Summary, located in the EMR under the Orders tab did not include the use of splints. Observations made 08/05/24-08/09/24 did not include R4 wearing splints. During an interview on 08/09/24 at 4:41 PM, with the Director of Nurses (DON), the DON confirmed that R4 did not wear or have an order for splints and that the care plan should not have included splint usage. The DON confirmed that R4 had not worn splints. 2. Review of R99's Admission Record, located in the EMR under the Resident tab revealed an original admitted [DATE]. R99's primary diagnosis was acute and chronic respiratory failure. Comorbidities included anoxic brain damage and persistent vegetative state, and dependence on respirator/ventilator. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R99's quarterly MDS with an ARD of 07/10/24 located in the EMR under the MDS tab did not include a BIMS due to inability to participate. Review of R99's Care Plan, located in the EMR under the Care Plan tab included providing smoking cessation information/assistance/resources. Review of the facility document of the list of smokers did not include R99. During an interview on 08/09/24 at 9:50 AM with the Director of Nursing (DON) confirmed that R99 had been in a vegetative state since admission and was not a smoker. The DON confirmed that the care plan was marked in error and would need to be updated. 2. Review of R101's Admission Record, located in the EMR under the Resident tab revealed an original admitted [DATE] and readmission on 11/13/22. R101's primary diagnosis was acute and chronic respiratory failure with hypoxia. R101's family member was R101's responsible party (RP). Review of R101's quarterly MDS with an ARD of 05/23/24 located in the EMR under the MDS tab included a BIMS score of 15 out of 15, indicated R101 was cognitively intact. Review of R101's Multidisciplinary Care Conference, note located in the EMR under the Assessments tab and dated 05/21/24 and indicated the resident had no discharge plan with plans to remain long term. Documentation did not include an invitation for the resident to attend. During an interview on 08/05/24 at 1:38 PM with R101 revealed he had not been invited to any care conferences and would like to attend. During an interview on 08/08/24 at 1:00 PM with Social Services (SS1) stated that she did not recall if R101 had been invited to attend his care conferences. It was her understanding that any residents that had been in the facility for more than 90 days were considered long-term care status and had not been routinely invited to attend their care conferences unless they are their own responsible party regardless of their cognitive status. During an interview on 08/08/24 at 2:40 PM with Social Services Director (SSD) confirmed that all cognitively intact residents, regardless of responsible party status should be invited to attend their care conference meetings.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interviews, record reviews, and facility policy review, the facility failed to develop, assist, and follow through to completion with discharge plans for one of 46 sampled residents (Resident (R)101) reviewed for discharge planning. The facility did not have a person-centered discharge plan for R101. Findings include: Review of the facility's policy titled Discharge and Transfer of Residents, revised 02/2018, stated, .When a resident is admitted to the Facility, Facility Staff will initiate a discharge plan .Discharge planning will begin on the residents' admission to the Facility .The Attending Physician will review the resident's progress and determine a possible discharge date with information from the IDT . Review of the facility's policy titled Resident Rights, revised 01/01/12, stated, .State and federal laws guarantee certain basic rights to all residents of the facility. These rights include, but are not limited to, a resident's right to: .participate in decisions and care planning . Review of R101's Admission Record, located in the electronic medical record (EMR) under the Resident tab revealed an original admitted [DATE] and readmission on 11/13/22. R101's primary diagnosis was acute and chronic respiratory failure with hypoxia. R101's family member was R101's responsible party (RP). Review of R101's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/23/24 located in the EMR under the MDS tab included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicated R101 was cognitively intact. During an interview on 08/05/24 at 1:38 PM, with R101 revealed R101 wanted to know what the plan was for returning home. R101 stated R101 had not attended any meetings to discuss discharge planning. During an interview on 08/08/24 at 1:00 PM, with Social Services (SS1) stated that R101 did not have a discharge plan in place due to R101 being a long-term care resident. Long term care was considered for anyone remaining in the facility past 90 days. SS1 confirmed that R101 was assigned to her caseload, and she had not discussed R101's wish to return home with R101. During an interview on 08/08/24 at 2:40 PM, with Social Services Director (SSD), SSD confirmed that all residents should be asked what their discharge goals and desires are. SSD was unaware of SS1 not speaking with R101 regarding discharge preferences.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27375 Based on interview, and record review, the facility failed to make an ophthalmologist referral order for one out of one resident (Resident (R)100) who needed cataract surgery. This failure effected one of 45 sampled residents. Findings include: Review of R100's Face Sheet located in the Profile tab of the electronic medical record (EMR), revealed R100 was admitted to the facility on [DATE] with the following diagnoses: diabetes mellitus with diabetic chronic kidney disease, and unspecified affecting left nondominant side. , Review of R100's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/07/24, located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R100 was moderately intact for decision-making. Review of R100's Physician Orders located in the physician order tab of the EMR last order review: 08/05/24, revealed there was no physician order for R100 to receive cataract surgery. Review of R100's Referral for follow-up ophthalmology care form dated 10/16/23 located in the resident's EMR under the miscellaneous tab revealed Please refer the above-named patient to their primary care physician for a referral to a local ophthalmologist according to their health plan. In an interview on 08/07/24 at 10:45 AM, R100 stated about a year ago she saw a doctor and was told she had a cataract in her right eye that needed to be removed. R100 stated she was given another appointment, but the staff here kept cancelling her appointments. R100 also stated the staff at the facility did not want her to see an eye doctor. R100 also stated her vision in her right eye was cloudy. In a phone interview on 8/8/24 at 10:43 AM, the receptionist at the ophthalmologist office stated a referral for R100 to get cataract surgery was sent to Alameda Social Services Dept the facility on 11/16/23. In an interview on 08/08/24 at 5:41 PM, Social Services (SS)1 stated she did not remember receiving an ophthalmologist referral for R100. SS1 also stated she was a new employee at the time and was not providing ancillary services at the time. In an interview on 08/09/24 at 2:44 PM, the Social Services Supervisor (SSS) stated he did not remember getting an ophthalmologist referral for R100, but he would follow-up immediately. Review of the facility's policy and procedure titled, Referral to Social Services with a revised date of 12/01/13, indicated, Residents, families and Facility staff are to be made aware of the services provided and coordinated by the Social Services Staff to provide for the residents' medical and psychosocial wellbeing.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on record review, observation, and interviews, the facility failed to follow physician orders for enteral feeding for one resident (Resident (R) 38) out of 24 residents with feeding tubes. This failure increased the risk for dehydration and weight loss for the resident. Findings: Review of R38's Admission Record located in the electronic medical record (EMR) under the Resident tab revealed an original admitted [DATE] and readmission on 11/10/17. R38's primary diagnosis was chronic respiratory failure with hypoxia (lack of sufficient circulating oxygen). Review of R38's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 07/19/24, located in the EMR under the MDS tab did not include a BIMS due to inability to participate. Review of R38's Physician Orders located in the EMR under the Orders tab included orders dated 01/10/22, lorazapem 0.5 milligrams (mg), give one tablet via gastrostomy tube (g-tube, a tube inserted through a surgically created opening through the abdomen into the stomach to deliver fluids, nutrients and medications), three times a day for anxiety; and 01/03/24 enteral feed (feeding delivered through the g-tube) twice a day, Jevity 1.5 (type of formula), at 60 ml/hr for 20 hours to provide 1200 calories per day. Feeding to be turned on at 12:00 PM, turned off at 8:00 AM. Review of R38's MAR revealed the enteral feeding was not started on 08/06/24 at 12:00PM. During an observation and interview on 08/06/24 at 1:25 PM, in the room of R38, R38's spouse was in the room and stated the enteral feeding pump was not turned on and had not been turned on since R 38's spouse arrived at the facility at 12:50 PM. During an observation and interview on 08/06/24 at 2:52 PM, in R 38's room, R38's feeding pump was not turned on, although the physician order was to turn on the pump at 12:00 PM. Registered Nurse (RN)1 confirmed R38's feeding tube should have been turned on at 12:00 PM, but RN 1 stated had not had the time to turn the pump on, so R 38 had not received enteral feeding from 8 AM to 3 PM. Calculation of the time from noon, when the pump was ordered to be turned on, to 3 PM indicated a loss of three hours of fluid and nutrients equal to 15% of the daily ordered nutritional total of 20 hours.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on interviews, record review and policy review, the facility failed to ensure that dialysis communication sheets were complete for one of one resident (Resident (R) 16) reviewed for dialysis out of a total sample of 47 facility residents. This failure placed all residents that receive dialysis at this center in potential risk of impaired continuity of care. Findings include: Review of facility policy titled, "Dialysis Care," revised 10/01/18, revealed, "To provide dialysis care for residents in renal failure and those residents who require ongoing dialysis treatments .Procedure .4. Communication and Collaboration: A. The nursing staff, dialysis provider staff, and the attending physician ("Dialysis Staff") will collaborate on a regular basis concerning the resident's care as follows: i. Nursing staff will communicate the following information in writing to the dialysis staff: a. The resident's current vital signs; b. Weight; and c. Any changes of conditions specific to the resident with each treatment. ii. The dialysis provider will communicate in writing to the facility any problems encountered while the resident was at the dialysis provider and any ongoing monitoring required. iii. Nursing staff will keep the attending physician, the resident and the resident's family informed of any change in conditions. iv. Nursing staff may use NP-37-Form A-Pre/Post dialysis assessment to convey information to the dialysis provider." Review of "Admission Record" under the "Profile" tab in the electronic medical record (EMR) indicated that R16 was readmitted on [DATE] was a diagnosis of end stage renal disease (ESRD). Review of "Physician Order," under the "Orders" tab in the EMR indicated that "R16 goes to [name of dialysis center] on Tuesday, Thursday, and Saturday." Review of facility provided "Dialysis Communication Sheets," dated from January 2024-Current indicated no evidence for the following dates: 01/02/24, 01/04/24, 01/11/24, 01/18/24, 01/20/24, 01/25/24, 02/01/24, 02/24/24, 03/09/24, 03/16/24, 03/26/24, 03/28/24, 04/04/24, 07/06/24, 07/11/24, 07/23/24, and 08/03/24. There were 17 of 94 days of missing. Interview with R16 on 08/07/24 at 1:00 PM, she confirmed the dialysis center that she goes three times a week and takes her communication book with her. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 08/08/24 at 11:30 AM, confirmed that the communication sheets are not completed. Interview with the Director of Nursing (DON) on 08/08/24 at 12:20 PM, confirmed that the communication sheets were not completed; however, she expected that the nurses complete the pre-dialysis sheet, send to dialysis and upon return the nurse is to complete the post-dialysis portion of the communication sheets.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure side rails were used appropriately for three of four sampled residents (Resident (R)4, R30 and R99). This failure increased the risk for entrapment or injury for the three residents. Findings include: Review of the facility's policy titled Bed Rails revised 11/16/22, stated .A bed rail is an assistive device and must be used in accordance with the following regulations: a. Only permissible if they are used to treat a Resident's medical symptoms .d. Bed rails cannot be used for staff convenience or as discipline, such as prevention of falls when less restrictive methods have not been attempted or ruled out . 1. Review of R30's undated Admission Record located in the electronic medical record (EMR) under the Resident tab revealed an original admitted [DATE] and readmission on 09/21/22. R30's primary diagnosis was chronic respiratory failure with hypoxia. Comorbidities included encephalopathy, contractures, and anoxic brain damage. Review of R30's Care Plan updated 01/23/24 and located in the EMR under the Care Plan tab included use of bedrails/bilateral grab bars as enabler for bed mobility, turning and repositioning. Review of R30's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/02/24 located in the EMR under the MDS tab did not include a Brief Interview for Mental Status (BIMS) due to the resident not being able to participate. Additionally, the resident was dependent on staff for rolling left and right. Review of R30's Order Review History Report located in the EMR under the Orders tab included bilateral half side rails for assistance with turning and repositioning, dated 01/23/24. Review of R30's Bed Rail assessment dated [DATE] and located in the EMR under the Assessments tab, indicated the resident was non-ambulatory, did not have a history of falls, had poor bed mobility, had not expressed a desire to have side rails/assist bars for safety and/or comfort, there were no side rail replacement recommendations, and side rails/assist bars were not indicated at that time. During an observation on 08/05/24 at 11:00 AM, R30 laying supine in her bed, bilateral wrists/hands contracted, looking at the ceiling, non-verbal and had bilateral half rails on her bed. During an interview on 08/09/24 at 4:48 PM with the Director of Nursing (DON) confirmed that R30 had bilateral upper extremity contractures, was unable to move her extremities independently, and unable to use bed rails. The DON confirmed that the side rails should not have been on the bed and that they needed to be removed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R53's undated Admission Record located in the EMR under the Resident tab revealed an original admitted [DATE] and readmission on 06/06/21. R53's primary diagnosis was respiratory failure. Comorbidities included persistent vegetative state and contracture of unspecified joint. Review of R53's Care Plan updated 01/23/24 and located in the EMR under the Care Plan tab included use of bedrails/bilateral grab bars as enabler for bed mobility, turning and repositioning. Review of R53's quarterly MDS with an ARD of 05/16/24 located in the EMR under the MDS tab did not include a BIMS due to inability to participate. Review of R53's Order Review History Report located in the EMR under the Orders tab included bilateral grab bars as enabler for bed mobility and safety dated 01/23/24. Review of R53's Bed Rail assessment dated [DATE] and located in the EMR under the Assessments tab indicated the resident was non-ambulatory, did not have a history of falls, had poor bed mobility, had not expressed a desire to have side rails/assist bars for safety and/or comfort, bilateral side rail replacement recommendation, and side rails/assist bars were indicated to serve as an enabler to promote independence. During an observation on 08/05/24 at 10:56 AM, R53 was laying supine in his bed, bilateral wrists/hands contracted, non-verbal and had bilateral enabler bars on his bed. During an interview on 08/09/24 at 4:54 PM with the DON confirmed that R53 had bilateral upper extremity contractures, was unable to move his extremities independently, and unable to use enabler bars. The DON confirmed that enabler bars should not have been on the bed and that they needed to be removed. Review of R99's undated Admission Record located in the electronic medical record (EMR) under the Resident tab revealed an original admitted [DATE]. R99's primary diagnosis was acute and chronic respiratory failure. Comorbidities included persistent vegetative state and anoxic brain damage. Review of R99's Care Plan updated 01/10/22 and located in the EMR under the Care Plan tab included use of quarter rails for safety during care provision, and to assist with bed mobility. Review of R99's quarterly MDS with an ARD of 07/10/24 located in the EMR under the MDS tab did not include a BIMS due to inability to participate. Review of R99's Order Review History Report located in the EMR under the Orders tab included bilateral quarter siderails to aide in bed mobility and for safety dated 01/23/24. Review of R99's Bed Rail assessment dated [DATE] and located in the EMR under the Assessments tab indicated the resident was non-ambulatory, did not have a history of falls, had not expressed a desire to have side rails/assist bars for safety and/or comfort, there were no side rail replacement recommendations, and side rails/assist bars were indicated to serve as an enabler to promote independence. During an observation on 08/05/24 at 1:08 PM, R99 was laying supine in her bed, bilateral wrists/hands contracted, non-verbal and had bilateral quarter side rails on her bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/09/24 at 4:41 PM with the DON confirmed that R99 had bilateral upper extremity contractures, was unable to move her extremities independently, and unable to use side rails. The DON confirmed that the side rails should not have been on the bed and that they needed to be removed.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, record review, staff interviews, and policy review, the facility failed to ensure the facility provided appropriate treatment and services for one of one resident (Resident (R) 89) reviewed for suicidal ideations (SI). This failure had the potential to contribute to continued suicidal thoughts that could result in self-harm for R89. Findings include: Review of facility policy titled, "Referrals to Outside Services," revised 12/01/13, revealed, "To provide residents with outside services as required by physician orders or the care plan. Policy: 1. The Director of Social Services coordinates the referral of residents to outside agencies/programs to full fill resident needs for services not offered by the facility .2 .Examples of service provider contracts that the Director of Social Services may coordinate include but are not limited to psychiatric services." Review of "Admission Record," located under the "Profile" tab in the electronic medical record (EMR) indicated that R89 was readmitted to the facility on [DATE] with a traumatic brain injury (TBI), and schizophrenia. During the initial observational tour of the facility on 08/05/24 at 11:58 AM, R89 indicated that he did not want to be here anymore. R89 denied having a suicidal plan. R89 was observed to be tearful, but no crying observed. During observation on 08/06/24 at 10:43 AM, R89 was observed smiling and said that he was having a good morning. Denied having any suicidal thoughts. Review of "Social Service Note," located under the tab "Notes," dated 05/07/24, indicated, "During Minimum Data Set (MDS) assessment, R89 stated that he wanted to commit suicide. He has no plan that he spoke of when asked why he felt that way. Social services (SS) sent message for .psychiatrist to get next steps." Review of "Social Service Note," located under the tab "Notes" dated 08/05/24 indicated "Resident said that he wants to be out of the skilled nursing facility (SNF) and return home as soon as possible. He said he is not suicidal, but is lonely, and sad." Review of "Social Service Note," located under the tab "Notes" dated 08/08/24 indicated " .R89 was not seen by the psychologist." Interview with Social Service (SS)1 on 08/08/24 at 12:51 PM, indicated that once a referral to psych is made, there is no check and balance to ensure that the consult has been completed. If any resident has any suicidal thoughts, she will discuss if the resident has any plans, and she would alert the nurse. In addition, SS1 makes a psych referral; however, no further follow up after that. (continued on next page)

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	555486	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Healthcare & Wellness Center	430 Willow Street Alameda, CA 94501

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Social Service Supervisor (SSS) on 08/08/24 at 2:04 PM, confirmed that back in May 2024, R89 expressed some suicidal ideations, and confirmed that a psychological referral was made, but there was no follow up completed. Said that SS1 should be following up with these referrals. Said that R89 was seen today, and it was determined that R89 was severely depressed.

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NAME OF PROVIDER OR SUPPLIER: Alameda Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 430 Willow Street Alameda, CA 94501	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on observations, interviews, record reviews, and facility policy reviews the facility failed to provide administration of medication according to physician orders for nine of nine residents (Resident (R)16, R29, R33, R37, R38, R44, R45, R73 and R90) reviewed for medication administration. Specifically, the facility failed to properly document medication administration, failed to administer medication to one resident (R16), and failed to administer medications on time to eight of nine residents reviewed for medication administration (R29, R33, R37, R38, R44, R45, R73, and R90). These failures had the potential to result in decreased therapeutic results of the medications prescribed for the effected residents. Findings include: Review of the facility policy titled, Medication-Administration, revised 01/01/12 stated .Medications may be administered one hour before and after the scheduled medication administration time .The time and dose of the drug or treatment administered to the patient will be recorded in the patient's individual medication record by the person who administers the drug or treatment . Review of the facility policy titled, Medication-Errors revised 07/2018, stated, .All errors related to the administration of medications or treatments will be reported to the Director of Nursing Services, the attending physician, and the Administrator immediately .Medication Error means the administration of medication: .at the wrong time The Director of Nursing Services or his/her designee will investigate the error to determine the cause . 1. Review of R16's undated Admission Record, located in the electronic medical record (EMR) under the Resident tab revealed an original admitted [DATE]. R16's primary diagnosis was end-stage renal disease. Comorbidities included epilepsy, peripheral vascular disease, and glaucoma. Review of R16's Clinical Physician Orders located in the EMR under the Orders tab included aspirin EC (enteric coated) low strength tablet delayed release 81mg (milligrams) one tablet by mouth (PO) once daily (QD) for stroke prevention, folic acid 1mg one tablet PO QD for supplement, levetiracetam 1000mg one tablet in the morning PO for seizure prevention, vitamin C 500mg one tablet PO QD for supplement, vitamin D3 25 mcg two tablets PO QD for supplement, and refresh tears solution instill one drop in both eyes (OU) two times a day (BID) for dry eyes. Review of R16's Medication Administration Record (MAR) revealed he did not receive aspirin EC 81 mg tablet, folic acid 1mg tablet, levetiracetam 1000mg tablet, vitamin C 500mg tablet, vitamin D3 25 mcg 2 tablets, and refresh tears eye drops on 08/06/24 for the morning dose as evidenced by blank MAR documentation. Aspirin EC, folic acid, levetiracetam, vitamin C, and vitamin D3 were due for administration at 7:30 AM and amlodipine scheduled time on the MAR was for 9:00 AM. During an interview on 08/06/24 at 1:56 PM with Registered Nurse (RN1) confirmed that R16 had not received her morning medication due to the medication pass for R16's hall was very heavy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/06/24 at 2:00 PM with R16, R16 stated she didn't know why she hadn't received her morning medications. 2. Review of R29's undated Admission Record located in the EMR under the Resident tab revealed an original admitted [DATE] and readmission on 08/23/19. R29's primary diagnosis was seizures. Comorbidities included major depressive disorder. Review of R29's Physician Orders located in the EMR under the Orders tab included orders dated: 01/14/23 bupropion HCl (hydrochloride) ER (extended release) 24 hour 300 mg tablet, give one tablet PO every morning (Q AM) for depression; 04/06/24 ascorbic acid 500 mg tablet, give one tablet PO QD for wound healing; 03/07/24 sertraline HCl 100 mg tablet, give one tablet PO Q AM for depression; 09/30/23 magnesium 400 mg tablet, give one tablet PO QD for supplement; 12/31/22 glycolax powder, give 17 grams PO QD for constipation; 08/06/22 docusate sodium 250 mg tablet, give one capsule PO BID for bowel regularity; 01/13/23 levetiracetam 750 mg tablet, give one tablet PO BID for seizure prevention; and 09/30/23 vitamin D3 1000 units , give one tablet PO QD for supplement. Review of R29's MAR, dated 08/06/24, revealed RN1 documented that she administered glycolax powder, bupropion hydrochloride (HCl) extended release (ER), ascorbic acid, magnesium, sertraline HCl, vitamin D3, docusate sodium, and levetiracetam, however, the resident refused all medications on 08/06/24 at 2:16 PM. Glycolax, bupropion HCl, ascorbic acid, magnesium, sertraline HCl, vitamin D3, docusate sodium, and levetiracetam were listed for 9:00 AM administration daily. During an observation and interview on 08/06/24 at 2:16 PM, Registered Nurse (RN1) did not offer R29 9:00AM medications until 2:16 PM. The resident refused medications at that time. RN1 did not give a reason as to why documentation indicated R29 accepted the medication. 3. Review of R33's Admission Record located in the EMR under the Resident tab revealed an original admitted [DATE]. R33's primary diagnosis was respiratory failure. Comorbidities included chronic obstructive pulmonary disease (COPD), stroke, schizoaffective disorder, benign prostatic hyperplasic, anemia, and gastro-esophageal reflux disease. Review of R33's Physician Orders located in the EMR under the Orders tab included orders, dated 01/06/24, albuterol sulfate HFA (hydrofluoroalkane) inhalation aerosol solution 108 mcg (micrograms)/act (actuation) two puff via tracheostomy four times a day (QID) for COPD, 12/21/23 finasteride 5mg tablet, give one tablet PO QD for BPH (benign prostatic hyperplasia), 12/04/23 docusate sodium 100mg tablets, give 2.5 tablets by mouth (PO), once a day (QD), for constipation, and 02/08/24 glycopyrrolate 1 mg tablet, give one tablet PO, BID for excessive secretions. Review of R33's MAR revealed R33 received the following medications late for August 2024: Albuterol sulfate on 08/05/24 due at 8:00 PM was not administered until 10:34 PM. Albuterol sulfate on 08/06/24 due at 8:00 PM was not administered until 10:29 PM. During an observation and interview on 08/07/24 at 11:18 AM Licensed Vocational Nurse (LVN1) did not offer R33 his 8:00AM medications (finasteride 5 mg, glycopyrrolate 1 (one) mg, vitamin D 25 mcg until 11:26 AM. LVN1 stated she was running behind due to having a lot of residents to pass medications to on this hall this (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of R38's Admission Record located in the electronic medical record (EMR) under the Resident tab revealed an original admitted [DATE] and readmission on 11/10/17. R38's primary diagnosis was chronic respiratory failure with hypoxia. Review of R38's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 07/19/24 located in the EMR under the MDS tab did not include a BIMS due to inability to participate. Review of R38's Physician Orders located in the EMR under the Orders tab included orders dated 01/10/22 lorazapam 0.5 mg give one tablet via G-tube TID for anxiety. Review of R38's MAR revealed he did not receive lorazepam 0.5 mg on 08/06/24 at 12:00PM as evidenced by blank MAR documentation. Review of R38's MAR revealed R38 received the following medications were late for August 2024: Lorazepam 0.5 mg tablet on 08/04/24 due at 5:00 PM was not administered until 6:55 PM. 5. Review of R44's Admission Record located in the EMR under the Resident tab revealed an original admitted [DATE] and readmission on 07/06/21. R44's primary diagnosis was end stage renal disease. Comorbidities included hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease. Review of R44's Physician Orders located in the EMR under the Orders tab included orders, dated 07/10/23, losartan potassium 50mg tablet, give one tablet PO at HS for hypertension; 02/01/23, diltiazem CD (controlled delivery) ER 120 mg capsule, give one capsule PO every evening for hypertension; and 01/15/23 furosemide 80 mg tablet, give one tablet PO every Monday, Wednesday, Friday and Sunday for fluid retention. Review of R44's MAR revealed R44 received the following medications were administered late in July 2024: Diltiazem CD ER 120mg on 07/01/24 due at 5:00 PM was not administered until 7:02 PM. Furosemide 80 mg on 07/29/24 due at 9:00 AM was not administered until 10:53 AM. 6. Review of R45's Admission Record located in the EMR under the Resident tab revealed an original admitted [DATE]. R45's primary diagnosis was encounter for surgical aftercare following surgery on the skin and subcutaneous tissue. Review of R45's Physician Orders located in the EMR under the Orders tab included orders, dated 07/11/24, metoprolol tartrate 25 mg, give 0.5 tablet PO BID for hypertension; 07/10/24 insulin lispro injection solution 100 units/ml, inject as per sliding scale (blood sugar: 70-150= zero units, 151-200= 3 units, 201-250= six units, 251-300= 9 units, 301-350=12 units, 351-400=15 units with meals for diabetes mellitus; 07/10/24 clonidine HCl 0.1 mg, give 1 tablet PO at bedtime for hypertension; 07/10/24 insulin glargine subcutaneous solution, inject 20 units subcutaneously at bedtime for diabetes mellitus; 07/10/24 amlodipine besylate 10 mg, give one tablet PO at bedtime for hypertension. Review of R45's MAR revealed she received the following critical medications late for August 2024: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Insulin glargine 20 units on 08/04/24 due at 9:00 PM was not administered until 11:05 PM. Clonidine HCl 0.1mg on 08/04/24 due at 9:00 PM was not administered until 11:05 PM. Amlodipine besylate 10mg on 08/04/24 due at 9:00 PM was not administered until 11:05 PM. 7. Review of R73's Admission Record located in the EMR under the Resident tab revealed an original admitted [DATE]. R73's primary diagnosis was degenerative disease of the nervous system. Review of R73's Physician Orders located in the EMR under the Orders tab included 07/25/23 amlodipine besylate 10 mg, give one tablet PO QD for hypertension, 08/05/24 hydralazine HCl 50 mg, give one tablet PO QD for hypertension, 01/26/24 metoprolol succinate ER 100 mg, give one tablet PO QD for hypertension, 07/25/23 isosorbide mononitrate ER 60 mg, give one tablet PO QD for hypertension, 07/28/23 methadone HCl Oral Solution 10 mg/5 ml, give 50 mg PO QD for pain. Review of R73's MAR revealed she received the following medications were administered late for August 2024: Hydralazine HCl 50mg on 08/02/24 due at 4:00 PM was not administered until 5:53 PM. Amlodipine besylate 10 mg on 08/06/24 24 due at 8:00 AM was not administered until 11:21 AM. Hydralazine HCl 50 mg on 08/06/24 24 due at 8:00 AM was not administered until 11:21 AM. Metoprolol succinate ER 100 mg on 08/06/24 24 due at 8:00 AM was not administered until 11:23 AM. During an observation and interview on 08/06/24 at 10:34 AM R73 was yelling out for a staff member. This surveyor approached the resident who then reported she had not received her morning medications. During an interview on 08/06/24 at 10:40AM with RN 1, RN 1 stated R73's medications were late due to RN 1 being busy. 8. Review of R90's Admission Record located in the electronic medical record (EMR) under the Resident tab revealed an original admitted [DATE]. R90's primary diagnosis was adjustment disorder with anxiety. Comorbidities included hypertension. Review of R90's MAR revealed she received the following critical medications late for August 2024: Levetiracetam 250 mg on 08/01/24 due at 8:00 AM was not administered until 5:36 PM. Gabapentin 300 mg on 08/01/24 due at 8:00 AM was not administered until 5:36 PM. Gabapentin 300 mg on 08/01/24 due at 12:00 PM was not administered until 5:39 PM. Gabapentin 300 mg on 08/02/24 due at 12:00 PM was not administered until 2:47 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/07/24 at 10:14 AM R90 reported she does not always get her seizure or blood pressure medications. During an interview on 08/08/24 at 12:36 PM with the Medical Director stated it was his expectation for medications to be administered within two hours before to two hours after the designated time. He was made aware of medications not being administered in a timely manner from time to time, but he was not aware of this being a current problem. At times the nurses have called him to verify that it was okay to give medications late or at a different time but the nurses should notify him with any late or missed medications. During an interview on 08/08/24 at 1:26 PM with the Pharmacist confirmed that the DON had previously notified him that the facility had timeliness of medication administration in the issues in the past, but the Pharmacist was not sure if this continued to be an issue. The Pharmacist's expectation was for the medications to be given half an hour before to half an hour after the designated time. The goal was to have medications given on a consistent basis. During an interview on 08/09/24 at 5:53 PM with Licensed Vocational Nurse (LVN) 7 stated if medications are not documented as administered, then it wasn't done. Also, if the nurse didn't administer the medication, then they should document why not administered and notify the physician. Medications may be given up to an hour before or an hour after the listed time on the MAR. LVN7 confirmed that the physician should be notified when medications are administered late. During an interview on 08/09/24 at 5:53 PM with LVN3 stated if medications are not documented as administered, then it wasn't done. Also, if the nurse didn't administer the medication, then they should document why not administered and notify the physician. Medications may be given up to an hour before or an hour after the listed time on the MAR. LVN7 confirmed that the physician should be notified when medications are administered late. During an interview on 08/09/24 at 6:26 PM with the Administrator confirmed that medication reviews and medication documentation were reviewed during the monthly quality assurance and performance improvement meetings (QAPI). She did not indicate that late administration of medications was currently a concern. During an interview on 08/09/24 at 6:50 PM with the DON confirmed that nurses should be administering medications within one hour of the ordered time, one hour before to one hour after the time on the MAR. Additionally, if a resident refused a medication the nurse should reattempt to administer the medication, and if still unsuccessful should notify the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 07246 Based on observations, staff interview, and policy review, the facility failed to remove expired medications, treatment, and intravenous supplies and topicals stored in one (Sub-Acute Medication Room) of four medication rooms. Findings include: Review of the facility's policy titled, Storage of Medications with an effective date of April 2008, indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier Under M indicated, Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. Observation of the Sub-Acute Medication storage room with the Director of Nursing (DON) on 08/08/24 at 10:33AM, revealed the following medications were expired: Erythromycin (an antibiotic) 200mg[milligram]/5ml [milliliter] liquid suspension with a filled date of 08/22/23. There was no open date and/or no discard date indicated on the bottle. Information on medication label indicated discard after 35 days when opened. Famotidine (acid controller) 40mg/5ml liquid suspension had an opened date of 05/10/24. The medication had a discard date of 06/10/24. The medication label instructions indicated to discard after 30 days. Oseltamivir Phosphate (treatment of Influenza) oral Suspension 6mg/ml had the following date written on box 06/03/24. The Oseltamivir Phosphate Oral Suspension box did not indicate an open date or discard date. Instructions on medication label indicated discard after 17 days. Further observation of the Sub-Acute Medication storage room with the DON revealed the following treatment and intravenous supplies and topicals were expired: Calamine Lotion 6oz bottle had an expiration date 02/2024. Grafco-Silver Nitrate Applicators 75% Silver Nitrate, 25% Potassium Nitrate had an expiration date of April 2019. Dextrose 10% 1000cc bag intravenous (IV) use only had an expiration date of March 2024. During an interview on 08/08/24 at 10:33AM, with the DON during observation of the medication storage room, revealed that the facility has had problems with outdated medications and that they had done a sweep of the medication rooms and had removed the expired medications. The DON further stated that in the future a routine system to remove expired medications would be in place.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 21382 Based on interview, observation, and facility policy review, the facility failed to ensure the two of two dumpsters located in a fenced area located behind the building was not propped open as well as failed to ensure there was no bagged trash or refuse loose on the ground in the dumpster area. These failures could lead to vermin gathering around the dumpsters and potentially entering the facility. Findings include: Review of the facility policy titled, Waste Management, last revised on 04/21/22 revealed the purpose was, To reduce risk of contamination from regulated waste and maintain appropriate handling and disposable [sic] of all waste. The policy stated, . The Center's waste disposal system includes separate methods, for handling regulated, non-regulated and recycle waste. On 08/05/24 at 8:55 AM, the dumpster area was observed to have a several bags of trash on the ground, a stack of wooden pallets, broken down cardboard boxes, the blue dumpster was filled with items preventing the lid from closing properly, and the large green dumpster had one-half of the lid propped open by a white plastic pipe. On 08/06/24 at 8:55 AM, both dumpsters were observed open and broken-down cardboard boxes. During an interview on 08/07/24 at 12:20 PM, with the Dietary Supervisor about the dumpster area and she confirmed the area was not well maintained on the first two days of the survey. She stated garbage was picked later in the day on Monday and maintenance had cleaned up around the dumpsters. She confirmed the lid on the dumpster should be closed and not propped open by anything.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on interviews, record review and policy review, the facility failed to ensure that a contract was completed for a dialysis facility for one of one resident (Resident (R) 16) reviewed for dialysis out of a sample of 47 total facility residents. This failure placed all residents that receive dialysis at this center in potential risk. Findings include: Review of facility policy titled, "Service Agreements," 01/01/12, indicated, "To ensure consistency and uniformity when contracting with vendors and service providers, including physicians, in accordance with state and federal laws and regulations .Procedure: 1. The facility/Administrator will use approved Service Agreements contracting with vendors/consultants/providers whenever possible .4. Service Agreement Management: A. The Administrator will keep an original signed and dated copy of all service agreements with vendors/consultants/providers at the facility." Review of "Admission Record" under the "Profile" tab in the electronic medical record (EMR) indicated that R16 was readmitted on [DATE] was a diagnosis of end stage renal disease (ESRD). Review of "Physician Order," under the "Orders" tab in the EMR indicated that "R16 goes to [name of dialysis center] on Tuesday, Thursday, and Saturday." Interview with the Administer on 08/07/24 at 4:30 PM, confirmed that [name of dialysis center] if the center that R16 goes to for her dialysis but the facility does not have a contract with this dialysis center.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on observations, interviews, record reviews, and facility policy reviews the facility failed to ensure infection control was maintained for nine residents (Resident (R)15, R19, R30, R81, R87, R92, R94, R99, and R109) out of a total sample of 46 residents. Specifically, the facility did not maintain a sanitary urinal for R109, did not maintain hand hygiene during incontinent care for R15, R30, R87, and R99; did not maintain proper PPE protocol infection for residents on enhanced barrier precautions (EBP) protocol for R19, R81, R92, and R94. These failures had the potential to result in infection and the spread of infection. Findings include: Review of the facility policy's titled, Personal Protective Equipment, revised on 01/01/12 stated, .When gowns are used, they are used only once and discarded into appropriate receptacles located in the room in which the procedure was performed .Hands are washed before and after the removing of gloves . Review of the facility policy titled Resident Isolation- Categories of Transmission-Based Precautions revised on 01/01/12 stated .Contact precautions are implemented for residents known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. i. Examples of infections requiring Contact Precautions include, but are not limited to: .MRSA .gloves and handwashing .while caring for a resident, gloves are changed after having contact with infective material .gloves are removed before leaving the room and hands are washed immediately with an antimicrobial agent or a waterless antiseptic agent .The gown is removed and hand hygiene is performed before leaving the resident's environment . Review of the facility's policy and procedure titled Urinal and Bedpan - Offering and Removing with a revised date of 01/01/12 indicated, Policy: I. Assure the bedpan or urinal is clean before use. Procedure:.D. Remove the urinal or bedpan from the resident's bedside stand. Assure that it is clean and dry. I. Empty the bedpan/urinal into the commode. Flush the commode ,. Sanitize the bedpan/urinal. Wipe dry with a clean paper towel. Discard paper towel into designated container. store the bedpan or urinal; do not leave it in the bathroom or on the floor. Review of facility policy titled, "Personal Protective Equipment," revised 01/01/12, revealed, "To ensure the availability of personal protective equipment as required .Procedure .3. Protective clothing provided to our facility staff includes but is not necessarily limited to: A. Gowns .2. When gowns are used, they are used only once and discarded into appropriate receptacles located in the room in which the procedure was performed . B. Gloves .3. Gloves are used only once and are discarded into the appropriate receptacle located in the room in which the procedure is being performed. 4. Hands are washed before and after the removing of gloves." (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Alameda Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Willow Street Alameda, CA 94501	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy titled, ''Enhanced Barrier Precautions,'' revised 07/05/24, revealed, '' .Process: 2. For residents for whom enhanced barrier precautions (EBP) are indicated, EBP is employed when performing the following high-contact resident care activities for those at risk of transmission or acquisition of multidrug-resistant organisms (MDRO)s: b. Bathing/showering .h. Wound care: any skin opening requiring a dressing. 1. Per the Center for Disease Control and Prevention (CDC), this generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks, abrasions, or skin tears covered with a Band-aid or similar dressing. 2. Examples of chronic wounds include but are not limited to: 1. Pressure ulcers, diabetic foot ulcers, and chronic venous stasis ulcers.'' Review of facility provided CDC Sign titled, ''Enhanced Barrier Precautions,'' undated, revealed, ''Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities .Wound Care: any skin opening requiring a dressing.'' 1. Review of R15's undated Admission Record located in the electronic medical record (EMR) under the Resident tab revealed an original admitted [DATE] and readmission on 11/01/17. R15's primary diagnosis was chronic respiratory failure. Comorbidities included tracheostomy and gastrostomy tube status. Review of R15's Care Plan updated 04/23/24 and located in the EMR under the Care Plan tab included EBP due to tracheostomy and gastrostomy tube status.Maintain precautions by wearing appropriate PPE during resident care . Review of R15's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 07/29/24 located in the EMR under the MDS tab did not include a Brief Interview for Mental Status (BIMS) due to the resident not being able to participate. R15 was incontinent of bowel and bladder, had a feeding tube and tracheostomy. Review of R30's Physician Orders located in the EMR under the Orders tab did not include EBP status. During an observation on 08/08/24 at 7:48 PM Certified Nursing Assistants (CNA1 and CNA9) and Licensed Vocational Nurse (LVN5) performed hand hygiene, donned a mask, gown, and gloves prior to entering R15's room that had an EBP sign outside the door. The staff performed incontinent care but did not perform hand hygiene between glove changes and did not clean between the labia. During an interview on 08/08/24 at 8:15 PM with LVN5 confirmed that staff did not perform hand hygiene between glove changes or clean between the labia but should have. 2. Review of R30's undated Admission Record located in the EMR under the Resident tab revealed an original admitted [DATE] and readmission on 09/21/22. R30's primary diagnosis was chronic respiratory failure with hypoxia. Comorbidities included methicillin resistant staphylococcus aureus infection (MRSA), resistance to other specified betalactam antibiotics, tracheostomy and gastrostomy tube status. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R30's Care Plan updated 06/04/24 and located in the EMR under the Care Plan tab included contact precautions related to CRE (carbapenem-resistant enterobacterales) /KPC (klebsiella pneumoniae carbapenemase)/ CRAB (carbapenem-resistant acinetobacter baumannii) organisms.Maintain precautions by wearing appropriate PPE during resident care . Review of R30's quarterly MDS with an ARD of 06/02/24 located in the EMR under the MDS tab did not include a BIMS due to the resident not being able to participate. R15 was incontinent of bowel and bladder, had a feeding tube and tracheostomy requiring mechanical ventilation. Review of R30's Physician Orders located in the EMR under the Orders tab did not include contact precautions. During an observation on 08/08/24 at 8:05 PM, CNA1 and CNA9 performed hand hygiene, donned a mask, gown, and gloves prior to entering R30's room that had a Contact Precautions sign outside the door. The staff performed incontinent care but did not perform hand hygiene between glove changes. During an interview on 08/08/24 at 8:13PM with CNA1 and CNA9 confirmed that they had not performed hand hygiene between glove changes but should have. 3. Observation on 08/09/24 at 3:10 PM revealed CNA11 and CNA 8 were observed providing incontinent care to R87. After explaining the procedure to R87, CNA 11 donned a pair of gloves. CNA11 did not perform hand hygiene before donning the gloves. Further observation revealed, CNA8 donned a pair of gloves and did not perform hand hygiene before donning the gloves. CNA8 filled a basin with soapy water and dropped numerous wipes in the soapy water basin. CNA11 then proceeded to take a wipe from the soapy water basin and clean the top of (R)87's pubic area and with the same wipes cleaned the right side of the pubic area in a downward motion. CNA11 was then observed to clean the left side of the pubic area in a downward motion. CNA11 then spread the labia majora and with the same wipes and gloves wiped in a downward motion twice. With the same gloves, CNA11 then turned R87 on her right side. CNA8 was observed to clean fecal material from the resident's buttock cheeks and anal area without donning a clean pair of gloves and or performing hand hygiene. CNA8 then reached for a adult brief with the same soiled gloves and applied the adult brief to (R87). Still wearing the same gloves, CNA11 and CNA 8 were then observed to adjust the resident's gown and pull the bed sheet to the resident's chest. CNA 8 then reached for the residents blanket and placed it on the left side of the resident's face and shoulder. Interview with CNA11 and CNA8 immediately after the incontinent care procedure, on 08/09/24 at 3:10 PM CNA11 and CNA8 stated they should have washed their hands prior to the incontinent care and should have changed their gloves after cleaning the peri and buttock area. CNA11 stated that it was over a year since she has had hand hygiene training and CNA8 stated that she had had hand hygiene training three or four months ago. Review of the attendees for the lecture training for hand hygiene, enhanced barrier precautions and contact precautions, dated 06/07/24 revealed that CNA 11 and CNA8 were not in attendance for the hand hygiene, enhanced barrier precautions and contact precautions lecture. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Review of R92's undated Admission Record located in the EMR under the Resident tab revealed an original admitted [DATE]. R92's primary diagnosis was cardiac arrest. Comorbidities included gastrostomy tube and tracheostomy requiring mechanical ventilation. Review of R92's Care Plan updated 04/24/24 and located in the EMR under the Care Plan tab included EBP due to tracheostomy and gastrostomy tube status and Contact Precautions for CRE/KPC.initiate appropriate isolation precautions .initiate isolation precautions per order .staff to follow standard precautions, including proper hand washing techniques to minimize microorganism transmission .maintain contact precautions when providing resident care . Review of R92's annual MDS with an ARD of 05/21/24 located in the EMR under the MDS tab did not include a BIMS due to inability to participate. R92 was incontinent of bowel and bladder, had a feeding tube and tracheostomy requiring mechanical ventilation. Review of R92's Physician Orders located in the EMR under the Orders tab did not include EBP or Contact Precautions. During an observation 08/07/24 at 1:10 PM it was noted that R92 had an Enhanced Barrier Precautions sign outside his room. LVN4 was seen completing R92's care at the bedside while wearing a gown, mask, and gloves. LVN4 doffed her soiled gloves, exited the room and approached the medication cart outside the room. LVN4 applied hand sanitizer and kept on her gown as she exited the room. 5. Review of R94's undated Admission Record located in the EMR under the Resident tab revealed an original admitted [DATE]. R94's primary diagnosis was nontraumatic intracranial hemorrhage. Comorbidities included gastrostomy tube and tracheostomy requiring mechanical ventilation. Review of R94's Care Plan located in the EMR under the Care Plan tab included ventilator and gastrostomy tube status but did not include enhanced barrier precautions.Initiate appropriate isolation precautions .use universal precautions as appropriate . Review of R94's annual MDS with an ARD of 05/28/24 located in the EMR under the MDS tab did not include a BIMS due to inability to participate. R94 was incontinent of bowel and bladder, had a feeding tube and tracheostomy requiring mechanical ventilation. Review of R94's Physician Orders located in the EMR under the Orders tab did not include EBP or Contact Precautions. During an observation and interview 08/07/24 at 1:10 PM it was noted that R94 had an Enhanced Barrier Precautions sign outside his room. LVN4 was seen at R94's bedside taking a blood pressure while R94 was lying in bed. LVN4 was wearing a mask, gown, and gloves while at the bedside. LVN4 then doffed her gloves, did not perform hand sanitizing, and then approached the medication cart outside the bedroom while continuing to wear the exposed gown. During an interview at time of observation, 08/07/24 at 1:10 PM, LVN4 confirmed that R92 and R94 were on EBP for tracheostomy and gastrostomy tube status. LVN4 confirmed that she had not changed her gown between R92 and R94 stated that she forgot and that she thought it was okay to wear her gown outside of the room since she was only approaching the medication cart just outside the bedroom door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Review of R99's undated Admission Record located in the EMR under the Resident tab revealed an original admitted [DATE]. R99's primary diagnosis was acute and chronic respiratory failure. Comorbidities included gastrostomy tube and tracheostomy requiring mechanical ventilation. Review of R99's Care Plan updated 04/29/24 and located in the EMR under the Care Plan tab included EBP due to tracheostomy and gastrostomy tube status.Maintain precautions by wearing appropriate PPE during resident care .Observe proper precautions and PPE . Review of R99's quarterly MDS with an ARD of 07/10/24 located in the EMR under the MDS tab did not include a BIMS due to inability to participate. R15 was incontinent of bowel and bladder, had a feeding tube and tracheostomy requiring mechanical ventilation. Review of R99's Physician Orders located in the EMR under the Orders tab did not include EBP status. During an observation on 08/08/24 at 8:05 PM CNA1, CNA9 and LVN5 performed hand hygiene, donned a mask, gown, and gloves prior to entering R99's room that had an EBP sign outside the door. The staff performed incontinent care but did not perform hand hygiene between glove changes and did not clean between the labia. During an interview on 08/08/24 at 8:15 PM with LVN5 confirmed that staff did not perform hand hygiene between glove changes or clean between the labia but should have. 7. Review of R109's Face Sheet located in the Profile tab of the EMR, revealed R109 was admitted to the facility on [DATE] with the following diagnoses: malignant melanoma of skin, unspecified, , reduced mobility need for assistance with personal care cognitive communication deficit, muscle weakness (generalized). Review of R109's Quarterly MDS with an ARD of 05/22/24, located in the resident's EMR under the MDS tab revealed a BIMS score of 11 out of 15 which indicated R109 was moderately impaired for decision-making. Review of R109's Quarterly MDS with an ARD of 05/22/24, located in the resident's EMR under the MDS tab revealed in Section H Bladder and Bowel R109, is occasionally incontinent of bladder. During an observation on 08/05/24 at 12:51 PM R109 showed this surveyor his urinal that was hanging from his bedside table. The urinal had a yellowish and brown substance sticking to the inside of the urinal on two sides. With consent from R109 this surveyor took pictures of the urinal. In an interview on 08/07/24 at 4:23 PM Licensed Vocational Nurse (LVN) 6 stated when emptying a urinal, it should be emptied in the resident's toilet, spray with a cleaner and rinse. This surveyor showed LVN 6 pictures of the urinal. LVN 6 stated, that is gross, in that case it should be replaced. In an interview on 08/07/24 at 4:26 PM Certified Nurse's Aide (CNA) 4 stated when emptying a urinal it should be emptied in the resident's toilet, cleaned with water, rinse, and put it back in the resident's room. This surveyor showed CNA 4 pictures of the urinal. CNA 4 stated the urinal should have been thrown away and replaced with a new urinal. CNA 4 also stated the urinal should not have been in use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 08/07/24 at 4:40 PM the DON stated when emptying a urinal it should be emptied in the toilet, it should not be rinsed in the resident's bathroom sink, it should be rinsed in the utility room. This surveyor showed the DON pictures of the urinal. The DON stated the urinal should have been replaced. 8. During observation upon entering the facility on 08/05/24 at 9:10 AM, Certified Nursing Assistant (CNA) 1, came out of Room C into the hallway with person protective equipment (PPE) on to dispose of a washcloth into the soiled linen basket, and then went back into Room C. Interview with CNA1 on 08/05/24 at 9:28 AM, he confirmed that he should have taken off his PPE prior to leaving the room. 9. During observation on 08/05/24 at 10:46 AM, observed CNA2 come out of Room A, which was an enhanced barrier room and not sanitize her hands with two towels in her arms. CNA2 went into Room B, which was also on EBP; however, CNA2 did not sanitize her hands, nor did she don any PPE. At 10:50 AM, she was observed giving care to bed B without donning a gown. Interview with CNA2 on 08/05/24 at 11:35 AM, said that she did not know Room B was on EBP. Stated that she did not know why Room B was on these precautions and was unsure where she could get PPE, since there was none outside the door. Interview with the DON on 08/09/24 at 6:30 PM, confirmed that when a room is on enhanced barrier precautions, a sign and PPE should be outside the room door. The DON confirmed that hands must be sanitized before and after entering room, and PPE should be worn during care. The DON confirmed that PPE needs to be doffed prior to exiting room and no linen taken from one enhanced barrier precaution room to another.